May 29, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare and Medicaid Electronic Health Record Incentive Programs—Stage 3 Proposed Rule (File Code CMS-3310-P)

Submitted Electronically

Dear Mr. Slavitt:

I am writing today on behalf of the members of the American Medical Group Association. We appreciate the opportunity to provide input about proposed Stage 3 of the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs. AMGA represents multi-specialty medical groups and other organized systems of care, including some of the nation's largest, most prestigious integrated healthcare delivery systems. AMGA member medical groups employ nearly 130,000 physicians who treat approximately one in three patients in the United States. Most AMGA member medical groups have been early adopters of health information technology to help them deliver high-quality coordinated care to their patients in a team-based and collaborative manner, and they have been eager to embrace the Medicare and Medicaid EHR Incentive Programs, despite the operational challenges they have presented.

While we appreciate the emphasis Stage 3 places on streamlining the requirements for meaningful use of EHR, our members have significant concerns with many of the increased percentage thresholds required for compliance with the Stage 3 objectives, and we have some additional observations relating to the healthcare information technology industry's readiness for Stage 3. The Centers for Medicare and Medicaid Services (CMS) has also requested input in some specific areas, and AMGA's comments follow in the paragraphs below.

Calendar Year Reporting

Beginning in calendar year 2017, CMS has proposed to align the reporting period across all EHR Incentive Programs, i.e., eligible professionals (EPs), eligible hospitals, and critical access hospitals

(CAHs) in both the Medicare and Medicaid EHR Incentive Programs to a calendar year reporting period, eliminating the fiscal year reporting cycle that has been in place for hospitals and CAHs.

AMGA's member organizations have reacted favorably to the proposal of a calendar year reporting period across all EHR Incentive Programs and settings beginning in 2017. Our members support this proposal and believe this alignment would provide significant administrative relief to integrated healthcare delivery systems. For the first year of Stage 3, however, we recommend that the reporting period be 90 consecutive days, for new and current participants, because coordinating vendors and third-party interoperability partners takes time. It is not realistic to assume that all of them would be ready to work together at the same time, based on past experiences.

Topped Out Objectives and Measures

CMS invites public comments on their proposed approaches for determining topped out measures. The proposed rule states that CMS routinely evaluates clinical quality measures (CQMs) to monitor performance among providers. When performance is so high and varies so little that measures can no longer provide meaningful distinctions in performance, what CMS terms "topped out," CMS considers removing them from the measure set. CMS proposes two criteria, similar to approaches used in other CMS programs, to determine topped out measures. The first is statistically indistinguishable performance at the 75th and 99th percentile. The second is performance distribution curves at the 25th and 75th percentiles as compared to the required measure threshold. AMGA supports these proposed approaches for determining topped out measures, and their removal from the measure set is very helpful to large medical groups because it will ease reporting burdens. We appreciate CMS efforts to actively update measure sets when the reporting burden outweighs the value of the information being reported.

Objectives and Measures for Meaningful Use in 2017 and Subsequent Years

<u>Protect Patient Health Information (Objective 1)</u>

AMGA notes that requirements to protect patient health information already exist through the Health Insurance Portability and Accountability Act (HIPAA), and our medical group members take these requirements very seriously, however. The current wording of the measure can lead to confusion about the timing of required risk assessments. We request further clarification in the final rule as to the timing and frequency of the required risk assessments.

<u>Electronic Prescribing (Objective 2)</u>

Electronic prescribing continues to be an important priority in quality reporting efforts, and AMGA supports the continued requirements in the EHR Incentive Programs. We have one recommendation with respect to the hospital measure, however, which for Stage 3, would only count new or changed prescriptions toward the 25 percent compliance threshold. AMGA recommends that refills, in addition to new or changed prescriptions, should also be included in the prescribing activity measured for compliance with this objective.

<u>Computerized Provider Order Entry (Objective 4)</u>

This objective requires EPs, hospitals, and CAHs to use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing

the equivalent duties of a credentialed medical assistant; who can enter orders into the medical record per state, local, and professional guidelines.

Measure one for both EPs and hospitals proposes the use of CPOE 80 percent of the time for medication orders, which we believe is too great an increase for many EPs and hospitals, and AMGA urges CMS to reduce this compliance threshold. The other two CPOE measure proposals, for diagnostic imaging and laboratory orders, each have a 60 percent compliance threshold, and AMGA recommends that medication orders also have a 60 percent compliance threshold for the sake of consistency.

We also ask CMS to address the use of scribes and provide clarity in the requirements with respect to the use of scribes in the final rule. We also ask that CMS permit orders entered by scribes, in the presence of a physician, to count toward compliance thresholds for CPOE.

Patient Access to Electronic Health Information (Objective 5)

AMGA strongly supports making health information accessible to patients, since it will assist them in becoming active partners in their own healthcare, but we have some concerns with this objective. Measure one for this objective requires EPs to provide access for 80 percent of patients to view online, download, and transmit their health information or retrieve their health information through an application program interface (API) within 24 hours of its availability. The current requirement is four days, making the proposed 24-hour timeframe for Stage 3 very ambitious. Physicians need more time to review patient information before this information should be made available. The final rule should also define make clear what "availability" means in this measure. As worded in the proposed rule, it could mean within 24 hours of signature, within 24 hours of hitting the API interface, or within 24 hours of being received by the electronic chart, and it should be clarified in the final rule, which we hope will also extend the 24-hour period. In addition, AMGA is concerned about the requirement to provide patients with API access and requests that CMS reconsider this approach. APIs may not provide a secure enough platform for the exchange of patient information. The currently available APIs may not be well-established enough for widespread use, and we would request that the technology be allowed to mature before becoming a requirement for the meaningful use of EHR early in Stage 3.

Measure two for eligible hospitals and Critical Access Hospitals (CAHs) requires them to use clinically relevant information from a Certified Electronic Health Record (CEHRT) to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients discharged from the eligible hospital or CAH inpatient emergency department (place of service 21 or 23) during the reporting period. While we believe the same measure is acceptable for EPs, the patient relationship to a hospital or CAH is vastly different, with visits likely to occur much less frequently. We therefore believe that measurement for the provision of electronic access to patient-specific educational resources is most relevant for EPs who have established, and ongoing, relationships with their patients, and that hospitals and CAHs should not have such a high compliance threshold at this time. We suggest that a 10 percent threshold, building off of a similar and more achievable Stage 2 objective would be more appropriate.

Another major impediment to enabling the transmit function is the lack of a National Direct Address Directory. Absent such a directory, which we recommend that CMS assemble and maintain in order to support the objectives of the EHR Incentive Programs, local versions of addresses are being created, and the result, in many cases, is that individual providers or facilities will have multiple addresses for one entity, which creates confusion. It is essential that this issue be resolved for a successful transition to Stage 3.

Coordination of Care through Patient Engagement (Objective 6)

While AMGA members wholeheartedly agree with the principle of using the communication functions of CEHRT to engage with patients, the meaningful use requirement to have patients view, download, or transmit their own data has been problematic for many healthcare providers from the very beginning. Physicians have not been enthusiastic about being measured, and graded, on the performance of their patients, upon which they can exert varying levels of influence. Our medical group members understand the importance of patient engagement and have dedicated significant resources to this important goal, however, patients can be resistant to the use of technology for several reasons, including advanced age or lack of access to a computer. Meeting this requirement, even based on a relatively small percentage of patients, has required extensive resources and involvement of staff at nearly every level of an organization. AMGA therefore applauds the modification to the requirement found in the separate proposed rule on the EHR Incentive Program for the 2015 through 2017 timeframe published two weeks after the Stage 3 proposals were published. This proposal would require **a single patient** to view, download, or transmit their electronic health information, eliminating the compliance threshold percentage altogether, for 2015 through 2017. Ramping up to the proposed 25 percent compliance threshold for 2018, as proposed in measure one of this objective, is too large a leap in too short a time. We respectfully request that CMS consider a more realistic compliance threshold for Stage 3.

Patients who are seen in large, integrated, healthcare delivery systems may be asked to interact with only one patient portal, but in some cases, hospitals and outpatient settings may have different portals even within the same health system. Presently, patients are being encouraged to interact with multiple patient portals by physicians, specialists, health systems, and hospitals, further complicating the ability of individual EPs and hospitals to meet compliance thresholds for this measure, and CMS must take this into account when developing compliance thresholds.

Measure two for this objective would require secure messaging with 35 percent of unique patients having been sent a secure message. In the recently proposed rule with modifications to the EHR Incentive Program for 2015 through 2017, CMS has changed the requirement for meeting the existing Stage 2 measure to simply enabling electronic messaging with patients, proposing to eliminate the previous percentage threshold altogether. In light of this new proposal, the 35 percent threshold seems unreasonable, and especially so for hospitals and CAHs, since patients would be more likely to send and receive secure messages to or from their EPs. Therefore, we recommend that for measure two, the technology is turned on and successfully tested, but that there be no compliance percentage threshold requirement to meet. Forcing medical groups to meet an arbitrary threshold does not promote better communication or patient engagement. Use of secure messaging technology in and of itself does not translate into better patient care. Having the technology in place and ready for use in situations when it would improve patient care should satisfy the measure. However, if a compliance percentage must be assigned, we believe it should be no more than 10 percent.

CMS requests input on whether measure three, which would require the incorporation of patient-generated data, or data from non-clinical settings into the EHR, is appropriate for hospitals and CAHs or should be an option only for EPs. AMGA has concerns about whether this measure is appropriate for hospitals and CAHs because patients are not likely to have the same established and ongoing relationships with hospitals that they do with EPs.

Health Information Exchange (Objective 7)

Objective seven requires EPs and hospitals to provide a summary of care record when patients are transitioning or referred to another setting of care, to retrieve a summary of care record upon the first encounter with a new patient, and incorporate summary of care information from other providers into an EHR using CEHRT. While this proposal is laudable and would go a long way toward the provision of seamless healthcare, the requirements of this objective have been difficult for EPs and hospitals to meet in the EHR Incentive Programs, and AMGA believes the thresholds for each of the associated measures are all too high and should be reconsidered before becoming final.

There are several barriers to compliance, one of which is a lack of Health Information Services Providers (HISPs) which are becoming operational slowly, with little information available about whom is connected by them. As discussed above, a major roadblock to enabling EHR-to-EHR exchanges of information, as required in this objective, is the lack of a provider National Direct Address Directory, and that issue must be addressed before 2018. The vision published in *Connecting Health and Care for the Nation, A Shared Nationwide Interoperability Roadmap DRAFT*[1] states that "An interoperable health IT ecosystem makes the right data available to the right people at the right time among disparate products and organizations in a way that can be relied upon and meaningfully used by recipients," but also acknowledges the current limitations and that true interoperability is not yet possible.

Measures two and three focus not only on transitions of care and referrals, but also on patients never before seen by a provider. As mentioned above, the infrastructure to identify summary of care records for newly seen patients is not mature enough to support this requirement, and we suggest that these measures be modified accordingly.

Public Health and Clinical Data Registry Reporting (Objective 8)

Objective 8 requires EPs, hospitals, and CAHs to be in active engagement with a public health agency (PHA) or a clinical data registry (CDR) to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice. EPs must successfully attest to three out of five measures, and hospitals and CAHs must successfully attest to four out of six measures, which represents a steep reporting burden given that bi-directional communication between providers and public health agencies is not a fully mature capability. AMGA recommends reducing the number of measures that EPs, hospitals, and CAHs must meet in order to comply with this objective to two out of five, and two out of six, respectively. Public health and clinical data registries are not uniformly ready to accept data from organizations, and we believe that they need more time to test and stability their systems.

In closing, AMGA appreciates CMS efforts to simplify Stage 3 and to continue the alignment of reporting requirements across all quality reporting programs. Some additional modifications should be made to make the program more workable for EPs, hospitals, and CAHs, however, and we request thoughtful consideration of our comments. AMGA, and its member medical groups, stands ready to be a resource to CMS now and in the future, as the agency develops the regulatory framework to implement H.R. 2,

[1] The Office of the National Coordinator for Health Information Technology. *Connecting Health and Care for the Nation, a Shared Nationwide Interoperability Roadmap, DRAFT Version 1.0*. March, 2015.

the “Medicare Access and CHIP Reauthorization Act of 2015” which will require alignment of the existing EHR Incentive Programs, the Physician Quality Reporting System, and Value-Based Modifier initiatives into a single program.

Should you have questions, please do not hesitate to contact Karen Ferguson, Senior Director of Public Policy, at keferguson@amga.org

Sincerely,

Donald W. Fisher, Ph.D.
President and CEO